STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445126	A. BUILDING _____ B. WING _____	08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, SEQUATCHIE	360 DELL TRAIL, PO BOX 878 DUNLAP, TN 37327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide activities of interest for three (#130, #121, #152) of seventeen congnitively impaired residents of thirty-nine residents reviewed. The findings included: Resident #130 was admitted to the facility on March 22, 2012, with diagnoses including Alzheimer's Disease, Alzheimer's Dementia with Behaviors, Manic Bipolar Disorder, Paranoid Delusions, and Depression. Review of the Admission Minimum Data Set dated April 2, 2012, revealed resident #130 had a score of 3 out of 15 (severely impaired) on the Brief Interview for Mental Status (BIMS); no evidence of acute change in mental status; and wandering on a daily basis. Medical record review of the Interview For Preferences dated March 28, 2012, and the Recreational Assessment dated March 30, 2012, revealed resident #130 had the following preferences as "Very Important": clothes to wear, choose tub, bath, shower, choose own bedtime,	F 248	The Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anthony Pyle	Administrator	9/18/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 248	Continued From page 1 place to lock your things in a safe place, to do things with groups of people, outside for fresh air, and to participate in religious events. Further review revealed the following as "Somewhat Important": have books, magazines, newspapers to read, listen to music-gospel and country, be around animals, and to do favorite activities-watch TV-news and game shows. Review of the Interim care plan dated March 22, 2012, revealed an approach for "...10. Encourage activity attendance..." Review of the care plan dated April 12, 2012, revealed an approach under the Hx (history) of behaviors related to Alzheimer's Disease with Behaviors, Manic Bipolar Disorder, & (and) Paranoid Delusions of "...Avoid over stimulation...". Further review revealed: problem addressing: "Resident frequently leaves programs early walking out of activity programs when encouraged to stay...Goal: Resident will attend at least one group activity with out leaving the program for at least five minutes, one time weekly... Approaches: Invite and directly guide Resident to group programs of interest: country and gospel music, dog and cat related activities, outdoor socials, church programs; Provide TV viewing area; Gently attempt to re-direct resident's attention as necessary within the resident's tolerance to remain in the programs or to remain on task; and Provide one-to-one attention during group programs as an attempt to keep on task." Review of the Interim care plan dated June 11, 2012, revealed no activity approaches.	F 248		

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F 248	Continued From page 2 Review of the care plan dated July 3, 2012, revealed the identical problems, goals and approaches written in the April 12, 2012, care plan addressing the Behavior problem with the approach to avoid over stimulation and the problem addressing the resident frequently leaving programs. Observations of resident #130 revealed the following: 1. On August 27, 2012, at 9:20 a.m., in the 500 wing Activity room revealed the resident sitting in the activity room watching a DVD of kittens which ran continuously. 2. On August 27, 2012, at 10:45 a.m., the resident was walking on the 500 hallway, and was frequently going up to different staff and talking. 3. On August 28, 2012, at 9:30 a.m., the resident was walking down the 500 hallway. 4. On August 28, 2012, at 10:30 a.m., the resident was standing at the exit door asking someone to let him out. 5. On August 29, 2012, at 9:45 a.m., the resident was wandering in and out of rooms and down the 500 hallway. 6. On August 29, 2012, at 2:30 p.m., the resident was sitting in the activity room with TV on. 7. On August 29, 2012, at 4:15 p.m., the resident was walking up and down the 500 hallway. Resident #121 was admitted to the facility on June 13, 2012, with diagnoses including Alzheimer's Disease, Dementia with Behaviors, Hypertension, Psychosis, Gastrointestinal Reflux Disease, Anxiety State and Benign Prostatic	F 248		

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F 248	Continued From page 3 Hyperplasia. Medical record review of the admission Minimum Data Set (MDS), dated June 18, 2012, revealed the resident was moderately cognitively impaired and required extensive assistance with transfer and eating. Observation on August 29, 2012, at 7:15 a.m., on the 500 Wing Hallway, revealed the resident wandering in and out of another resident's room. Observation on August 29, 2012, at 9:18 a.m., in the 500 Wing Hallway activity room, revealed the resident in a wheel chair going into the hallway and pushing another resident's wheel chair. Observation on August 29, 2012, at 9:40 a.m., in the 500 Wing Hallway, revealed the resident pushing the wheel chair into the closed door. Observation on August 29, 2012, at 3:20 p.m., in the 500 Wing Hallway, revealed the resident in the wheel chair attempting to pull a picture off the wall, when staff re-directed the resident into the activity room. Observation on August 30, 2012, at 8:00 a.m., revealed the resident in the wheel chair going up and down the 500 Wing hallway. Observation on August 30, 2012, at 10:00 a.m., revealed the activities coordinator placed a video in the DVD player for the residents to watch. Continued observation at 1:00 p.m., revealed the same DVD playing on a continuous loop to "select play".	F 248		

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F 248	Continued From page 4 Interview with Licensed Practical Nurse (LPN) #4, on August 29, 2012, at 7:45 a.m. in the 500 Wing Hallway Nurse's Station, revealed "...the first activity is started right after breakfast...weekend activities are scheduled on the weekends but the nurses are responsible to get them started...the CNAs are so busy they do not have time to be in the activity room all the time..." Interview with the Social Services Director, on August 29, 2012, at 10:00 a.m., in the Social Service office, revealed "...on the weekends they have things they can do but the nurses have to get the stuff out there...they can do things when they have time to get them out for the residents ..." Interview with Certified Nurse Assistant (CNA) #5, on August 29, 2012, at 10:30 a.m., in the 500 Wing Hallway, revealed "...activities department assists with activities and sometimes we help to get the resident's to the activity room after the bath...there are limited activities on the weekends...the only thing they may do is watch TV or a church comes in and sings..." Interview with LPN #9, on August 29, 2012, at 3:45 p.m., in the 500 Wing medication room, revealed "...activities are limited on the evenings and weekends...they have books, movies and balloon toss but it does not hold residents attention...it's hard to keep track with them (residents) and do all the other things we have to do..." Interview with CNA #4, on August 29, 2012, at 3:50 p.m., in the 500 Wing Hallway, revealed "...activities are in the activity room...can watch a	F 248		

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F 248	Continued From page 5 movie...no other activities in evening...there are only two CNAs on the 500 Wing Hallway... we get them fed and then start getting them ready for bed or they will start going in and out of other rooms wanting to go to bed..." Interview with the Activities Coordinator on August 30, 2012, at 10:06 a.m., in the activity coordinator's office, revealed "...the goals for resident #121 are to stay on task and to be involved directly with the resident...we (activity staff) try to get the residents into the activity room but there are only two of us...we have volunteers sometimes on the weekends such as churches...the nurses assist the residents with activities on the weekends and the evening shift...staffing is an issue...the activity department is spread thin..." Continued interview confirmed the activity coordinator had placed the DVD in the player on August 30, 2012, and "got busy" and "forgot to come back and take the DVD out of the player." Resident #152 was admitted to the facility on August 10, 2012, with diagnoses including Alzheimer's Disease, Dementia with Behaviors, Chronic Pain Syndrome, Sensorineural Hearing Loss, Bilateral, Dyslipidemia, Anxiety. Observation of Resident #152 on August 27, 2012, at 1:00 p.m., and 4:00 p.m., on the 500 unit, revealed the resident was not involved in any activities. Observation of the resident on August 28, 2012, at 10:00 a.m., on the 500 unit, revealed the	F 248	1. The Plans of Care for Residents #130, 121, and 152 have been revised to offer more activities of interest as well as more "hands on" activities. 2. All residents in the secured unit have been reviewed and the Plans of Care revised to offer more activities of interest. 3. The Activities Staff is being rescheduled to provide more consistent, individualized activities for the residents of the secured unit on weekends and in the evening. Individualized Memory Boxes are being compiled for each resident in the Secured Unit. The secured resident's families are being invited to participate in compiling the memory boxes. Those residents without families will have Memory Boxes made up of items pertaining to their past. Other items will be made available in the Secured Unit to provide tactile and sensory stimulation.	

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F 248	Continued From page 6 resident was not involved in any activities. Observation of the resident on August 29, 2012, at 9:45 a.m., revealed the resident in the activity room of the secure unit with no activities in progress. The television was on but the resident was not watching it. Observation of the resident on August 29, 2012, at 2:15 p.m., revealed the resident on the patio with eight other residents and the activity staff present. The resident was not engaged with the activity. Observation on August 29, 2012, at 5:00 p.m., revealed the resident sitting in the activity room of the 500 unit with the television on, but not watching it. Further observation on August 29, 2012 at 5:30 p.m. revealed the resident lying on the couch in the secured activity room. Interview with the Activity Director on August 29, 2012, at 8:45 a.m., in the dining room of station two, revealed the resident did not participate much in group activities and no activity personnel were available on the weekends. Activities on weekends were done by nursing staff or volunteers, and there had been less volunteers available lately. Interview with Licensed Practical Nurse (LPN) #4 on August 29, 2012, at 10:30 a.m., at the station two desk, confirmed there were no activity staff available on the weekends, and the LPN would sometimes do activities, but didn't always have the time. Further interview with LPN #4 confirmed the residents were often left with nothing to do, and the facility had failed to meet	F 248	4. An Activities Committee has been formed to coordinate the activities in the Secured Unit and incorporate new residents as they are admitted. The Committee will be composed of Activities Staff, Secured Unit Nurse and Secured Unit CNA. The Committee will provide ideas for activities and feedback on existing activities. The Committee will report findings to the Quality Assurance Committee.	10/14/12

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F 248	Continued From page 7 their activity interests.	F 248		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide housekeeping and maintenance services necessary to maintain equipment in a sanitary conditon for one of two whirlpool rooms and failed to repair or replace torn areas of a geri-chair. The findings included: Observation on August 30, 2012, at 12:35 p.m., in the Station 1 whirlpool room, revealed a Maximove (Arjo) lift with dirt and debris located on the lower stand. Interview with Licensed Practical Nurse (LPN) #1 on August 30, 2012, at 12:48 p.m., in the Station 1 whirlpool room, confirmed the lift was "dirty." Observation on August 30, 2012, at 3:15 p.m., in the 500 Hall activity room, revealed Resident #148 sitting in a geri-chair with tape on torn areas located on the head rest and half of the left arm rest. Interview with Certified Nursing Assistant (CNA) #4 on August 30, 2012, at 3:30 p.m., in the 500 Hall activity room, confirmed the geri-chair had	F 253	1. The Maximove (Arjo) lift in the Station 1 whirlpool room has been cleaned. The geri-chair in which Resident #148 was sitting has been removed from service. 2. All lifts and geri-chairs have been checked and all lifts cleaned as appropriate and all geri-chairs removed if in ill repair. 3. Assignments will be made specifically to check that lifts are cleaned and geri-chairs are in good repair. 4. A check list has been made to monitor lifts and geri-chairs to assure they are clean and in good repair. Nursing and Administrative Management staff will conduct reviews weekly for 4 weeks and monthly thereafter to assure standards are maintained. Results of the reviews will be reported to the Quality Assurance Committee.	10/14/12

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F 253	Continued From page 8 tape on torn areas of the head rest and half of the left arm rest.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		

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F 272	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure the comprehensive assessment was accurate for one resident (#131) of thirty-seven residents reviewed. The findings included: Resident #131 was admitted to the facility on March 21, 2012, with diagnoses including Alzheimer's Disease, Parkinson's Disease, Chronic Depression, Anxiety, Hypertension, Hypothyroidism, Osteoporosis, Arthritis, Macular Degeneration, and Diabetes Mellitus. Medical record review of the Significant Change in Status Minimum Data Set (MDS) Assessment dated June 21, 2012, revealed the resident had "...no natural teeth or tooth fragment(s) (edentulous)..." Medical record review of the Care Area Assessment (CAA) Summary dated June 21, 2012, for Dental Care revealed, "...0 (no) teeth present..." Medical record review of a physician's order and dental services consult report dated August 3, 2012, revealed the resident was to receive antibiotics and pain medication for two days related to surgical removal of a tooth.	F 272	1. Resident #131 has had a more recent comprehensive assessment done reflecting proper dental assessment. 2. All comprehensive assessments of all residents will be reviewed to assure dental assessment is accurate. 3. An inservice will be held with the nursing staff completing the comprehensive assessments to assure understanding of the resident assessment instrument on dental coding. 4. The MDS Coordinator will review all comprehensive assessments until there is 100% accuracy on dental coding and randomly thereafter. The MDS Coordinator will report findings to the Quality Assurance Committee.	10/14/12

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F 272	Continued From page 10 Observation and interview with the resident, in the resident's room, on August 29, 2012, at 3:50 p.m., confirmed the resident had natural teeth present and had one tooth removed the beginning of August because it had broken. Interview with the Assistant Director of Nursing on August 30, 2012, at 1:46 p.m., in the Social Service office, and review of the medical record confirmed the resident had upper and lower back partials, natural teeth to the upper and lower front, and the MDS was inaccurate.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		

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F 280	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the care plan for two residents (#118 and #81) of thirty-seven residents reviewed. The findings included: Resident #118 was admitted to the facility on May 30, 2011, with diagnoses including Dementia, Alzheimer's Dementia with Behavior Disturbance, Diabetes Mellitus, Insomnia, Renal Insufficiency, Depression with Anxiety, Hypothyroidism, Agitation, Anemia, and Blindness. Medical record review of the Care Plan dated August 7, 2012, revealed, "...At risk for altered skin integrity related to cognitive impairment and physical limitations...Skin assessments q (every) week. Direct care staff to monitor resident during routine care for any redness, open areas..." Medical record review of the Skin Assessment Record completed August, 7, 16, 21, and 28, 2012, revealed no "...alteration in skin integrity..." Observations of the resident on August 28, 2012, at 1:01 p.m., and on August 29, 2012, at 7:33 a.m., in the resident's room, revealed the resident lying in bed, sleeping, with a band-aid on the left forearm. Interview and medical record review with Licensed Practical Nurse (LPN) #1 on August 30, 2012, at 2:30 p.m., at nursing station 2, revealed the LPN was unaware of the band-aid to the left forearm, there were no skin treatments ordered	F 280	1. Late entry documentation has been made on the Skin Assessment Sheet of Resident #118 for August 28 – 30 noting the alteration in skin integrity. 2. All residents receiving care for skin issues will be checked to assure there is accurate and complete documentation on the dressing and in the medical record and that the care plan reflects care given. 3. An inservice will be held with the nursing staff to assure proper care is given and documentation is done for any alteration in skin integrity. 4. A check sheet has been devised to monitor all incidents to assure proper care and documentation is done for all incidents involving alterations of skin integrity. An Incident/Falls Committee will review each incident and a member of the committee will follow up with the resident and medical record to assure proper care, documentation on the dressing if applicable, and in the medical record as well as assuring the care plan is revised accurately. The Committee will report results to the Quality Assurance committee.	10/14/12

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F 280	Continued From page 12 for the left forearm, and was unaware of any skin issues for the resident. Interview with LPN #7 and observation of the resident on August 30, 2012, at 2:45 p.m., in the resident's room, confirmed the resident had a band-aid to the left forearm with no date present on the band-aid, and when the band-aid was removed a "lesion" was present. Further interview with the LPN confirmed the LPN was unaware of the "lesion" and did not know when the lesion developed, when the band-aid was placed, or who placed the band-aid. Interview and medical record review with LPN #7 on August 30, 2012, at 2:55 p.m., at nursing station 2, confirmed no documentation in the medical record or the Care Plan regarding the skin lesion to the left forearm. Resident # 81 was admitted to the facility on June 26, 2012, with diagnoses including Alzheimer's Disease, Dementia, Psychosis, Hypertension, Chronic Kidney Disease, Parkinson Disease and Depression. Medical record review of the significant change Minimum Data Set (MDS) dated July 2, 2012, revealed the resident scored a four on the Brief Interview for Mental Status indicating the resident was severely cognitively impaired and required extensive assistance with activities of daily living. Medical record review of the Care Plan dated July 10, 2012, revealed the resident had "...personal history of falls and at risk for injury...assist in transfers...non-skid shoes and socks...tab alarm	F 280		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445126	A. BUILDING _____ B. WING _____	08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, SEQUATCHIE	360 DELL TRAIL, PO BOX 878 DUNLAP, TN 37327

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F 280	Continued From page 13 while in bed and in chair...staff to make frequent checks on resident..." Medical record review of a nurses note dated July 29, 2012, at 5:05 a.m., revealed "...entered room and found resident lying in the floor on the right side...denies any pain or discomfort...alarm in use..." Medical record review of the care plan after the fall dated July 30, 2012, revealed "...pharmacy to review the meds (medications)..." Medical record review of the Medication Review form dated July 31, 2012, revealed "...Morphine, Ativan and Seroquel place the resident at risk for falls...please ensure that resident is on the lowest effective dose of these medications to decrease the risk of falls..." Medical record review of the Medication Review form with the physician's response dated August 13, 2012, revealed "...will review meds periodically and lower doses as needed..." Observation on August 29, 2012, at 7:32 a.m., in the resident's room, revealed resident #81 lying on the bed, two full side rails in place and a bed alarm in use. Interview with the unit manager, Registered Nurse (RN) #1, on August 30, 2012, at 2:30 p.m., in the unit managers office, confirmed the resident had a fall on July 29, 2012, the pharmacy consultation was done on July 31, 2012, and the facility failed to revise the care plan with new interventions for the prevention of falls.	F 280	1. Care Plan for Resident #81 has been updated with physician's response to the Pharmacist's recommendations. 2. All residents with recommendations from Pharmacy have been checked to assure care plan is updated. 3. An inservice will be held with all nurses to assure care plans are updated as appropriate. Nurse requesting pharmacy recommendations will follow up to assure recommendation was done and proper follow up documented. 4. The Director of Nursing or her designee will monitor the compliance with follow up and report to the Quality Assurance Committee.	10/14/12
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282 SS=E	Continued From page 14 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to document and assess a wound for two residents (#118 and #152); failed to provide a physician ordered psychiatric evaluation for one (#130); and failed to document and investigate of the cause of bilateral hand briuses to one (#119) of thirty-seven residents reviewed. The findings included: Resident #118 was admitted to the facility on May 30, 2011, with diagnoses including Dementia, Alzheimer's Dementia with Behavior Disturbance, Diabetes Mellitus, Insomnia, Renal Insufficiency, Depression with Anxiety, Hypothyroidism, Agitation, Anemia, and Blindness. Medical record review of the Care Plan dated August 7, 2012, revealed, "...At risk for altered skin integrity related to cognitive impairment and physical limitations...Skin assessments q (every) week. Direct care staff to monitor resident during routine care for any redness, open areas..." Medical record review of the Skin Assessment Record completed August, 7, 16, 21, and 28, 2012, revealed no "...alteration in skin integrity..."	F 282		

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F 282	Continued From page 15 Observations of the resident on August 28, 2012, at 1:01 p.m., and on August 29, 2012, at 7:33 a.m., in the resident's room, revealed the resident lying in bed, sleeping, with a band-aid on the left forearm. Interview and medical record review with Licensed Practical Nurse (LPN) #1 on August 30, 2012, at 2:30 p.m., at nursing station 2, revealed the LPN was unaware of the band-aid to the left forearm, there were no skin treatments ordered for the left forearm, and was unaware of any skin issues for the resident. Interview with LPN #7 and observation of the resident on August 30, 2012, at 2:45 p.m., in the resident's room, confirmed the resident had a band-aid to the left forearm with no date present on the band-aid, and when the band-aid was removed a "lesion" was present. Further interview with the LPN confirmed the LPN was unaware of the "lesion" and did not know when the lesion developed, when the band-aid was placed, or who placed the band-aid. Interview and medical record review with LPN #7 on August 30, 2012, at 2:55 p.m., at nursing station 2, confirmed no documentation on the skin assessments, nursing notes, treatment orders or care plan regarding the "lesion" or placement of the band-aid over the lesion. Resident #152 was admitted to the facility on August 10, 2012, with diagnoses including Alzheimer's Disease, Dementia with Behaviors, Chronic Pain Syndrome, Sensorineural Hearing Loss, Bilateral, and Anxiety.	F 282	1. Late entry documentation has been made on the Skin Assessment Sheets of Residents #118 and #152 noting the alteration in skin integrity. 2. All residents receiving care for skin issues will be checked to assure there is accurate and complete documentation on the dressing and in the medical record and that the care plan reflects care given. 3. An inservice will be held with the nursing staff to assure proper care is given and documentation is done for any alteration in skin integrity. 4. A check sheet has been devised to monitor all incidents to assure proper care and documentation is done for all incidents involving alterations of skin integrity. The Incident/Falls Committee will review each incident and a member of the committee will follow up with the resident and medical record to assure proper care, documentation on the dressing if applicable and in the medical record as well as the accurate revision to the care plan.	10/14/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 16 Observation of resident #152 on August 27, 2012, at 8:45 a.m., in the resident's room, revealed a left elbow abrasion with a bandage partially covering it. Further observation revealed the bandage had begun to fall off. Medical record review of the Weekly Skin Assessment Record revealed no skin problems for August 10th, August 11th, August 18th, and August 25, 2012. Medical record review of the care plan completed on August 28, 2012, revealed no documentation of any skin issues. Medical record review of the Physician's orders for August, 2012, revealed no orders for skin abrasions. Interviews on August 28, 2012, at 10:00 a.m., with Licensed Practical Nurse (LPN) #2 and the treatment nurse outside the 500 unit medication room, revealed both nurses were unaware of the skin abrasion. Medical record review of the nurses note dated August 28, 2012, at 10:40 a.m., by the treatment nurse revealed "Observed an area to the left posterior arm, scabbed area noted with no s/s (signs or symptoms) of infection area washed with soap and water and left open to air. Will report to physician and monitor and treat as ordered. " Medical record review of the nurses notes dated August 28, 2012, to August 30, 2012, at 12:30 p.m., revealed no orders for treatment of the skin	F 282		

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F 282	Continued From page 17 condition on the left elbow, and no documentation indicating the physician or family had been notified. Observation of the resident on August 30, 2012, at 3:45 p.m., with LPN #5, and LPN #4, in the resident's room, revealed a scabbed area on the left elbow which measured 20mm (milimeters) by 8mm and a reddened area two inches by one inch next to the scab. LPN #5 stated the physician and family would be informed. Further interview with LPN #5 confirmed the facility failed to conduct a comprehensive skin assessment. Resident #130 was admitted to the facility on March 22, 2012, with diagnoses including Alzheimer's Disease, Alzheimer's Dementia with Behaviors, Manic Bipolar Disorder, Paranoid Delusions, and Depression. Medical record review of the physician orders revealed a phone order dated "August 21, 2012, noted 1440 (2:40 p.m.) Paradigm (psychiatric services) to evaluate and tx (treat)." Medical record review of the nursing note dated "August 21, 2012 1440" revealed "Order noted for paradigm to eval (evaluate) and tx. Called spouse and left message. Awaiting call for approval." was signed by Licensed Practical Nurse (LPN) #4. Interview with LPN #4 at 3:10 p.m. on August 30, 2012, in nursing station 2, confirmed LPN #4 had left the message and received no return phone call from the spouse of the resident. Further interview confirmed LPN #4 failed to follow-up with the spouse to get approval for Paradigm to	F 282	1. The order for Paradigm services has been discontinued for Resident #130 since the spouse did not want the service and the resident's behavior has not required further intervention. 2. All resident's with orders for Paradigm services have been reviewed to assure the orders were carried out. 3. An inservice will be held with all nurses to assure all Paradigm orders are carried out in a timely manner. 4. The Director of Nursing or her designee will follow up with all Paradigm referrals to assure the proper procedure is followed and report to the Quality Assurance Committee.	10/14/12

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F 282	Continued From page 18 evaluate and treat the resident resulting in a delay of treatment. Resident #119 was admitted to the facility on June 22, 2012, with diagnoses including After Care for Healing Ankle Fracture, Hypertension, Atrial Fibrillation, Upper Respiratory Infection, and Urinary Tract Infection. Observation on August 28, 2012, at 8:31 a.m., revealed resident #119 with large bright yellow bruising to the top of both hands. Observation on August 29, 2012, at 8:00 a.m., revealed resident #119 with yellow colored bruising to top of hands fading more on the right hand than the left hand. Observation on August 30, 2012, at 9:30 a.m., revealed the resident had darker colored bruising on bilateral top of hands. Medical record review of the physician orders revealed a phone order dated August 24, 2012, for "...1) IV (Intravenous) NS (Normal Saline) at 75cc/hr (cubic centimeters per hour) 2) ...3) Clindamycin (antibiotic) 600mg (milligrams) IVPB (Intravenous Piggyback) q 8hr (every 8 hours) 4) Levaquin (antibiotic) 750mg IVPB q 24 hr x (times) 10 days..." Further review revealed a phone order dated August 26, 2012, to "...Decrease Levaquin to 500mg IV q 24hr; decrease rate NS to 50cc/hr..." Medical record review of nursing notes revealed: "...August 24, 2012, 1400 (2:00 p.m.)...#22 (name brand of IV catheter) placed in right hand after multiple sticks...skin condition: warm, dry,	F 282	1. Late entry documentation has been made in the Nurses Notes and on the Skin Assessment Sheets of Resident #119 noting the alteration in skin integrity. 2. All residents receiving care for skin issues will be check to assure there is accurate and complete documentation on the dressing and in the medical record and that the care plan reflects care given. 3. An inservice will be held with the nursing staff to assure proper care is given and documentation is done for any alteration in skin integrity. 4. A check sheet has been devised to monitor all incidents to assure proper care and documentation is done for all incidents involving alterations of skin integrity. The Incident/Falls Committee will review each incident and a member of the committee will follow up with the resident and medical record to assure proper care, documentation on the dressing if applicable, and in the medical record as well as the accurate revision to the care plan. The Committee will report results to the Quality Assurance committee.	10/14/12

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F 282	Continued From page 19 intact... 2020 (8:20 p.m.)... IV infusing to right hand. No signs infiltrate noted...August 25, 2012, 0220 (2:20 a.m.)...IV infusing right hand...August 25, 2012, 2140 (9:40 p.m.)...IV infusing right hand...with no signs infiltrate noted...August 26, 2012, 1000 (10:00 a.m.)...skin warm, dry, intact...August 26, 2012, 1140 (11:40 a.m.)...skin warm, dry, intact...reason for alert charting: IV ABT (antibiotic therapy)...observation and assessment findings: IV intact, List care Plan Approaches: monitor IV site, Outcome of Approaches: IV site w/o (without) redness...August 26, 2012, 1800 (6:00 p.m.)... NS infusing...August 27, 2012, 0100 (1:00 a.m.)...IV intact/patent, no s/s (signs/symptoms) of phlebitis or infiltration...continue IV ABT...August 27, 2012, 1400 (2:00 p.m.)...skin condition: warm, dry, intact...August 27, 2012, 1600 (4:00 p.m.)...right hand INT (IV catheter)...with redness. IV infiltrated...INT started in right (FA) forearm... 2245 (10:45 p.m.)...right forearm INT intact with no s/s of infiltration noted...August 28, 2012, 1900 (7:00 p.m.) right forearm INT intact...August 29, 2012, 0150 (1:50 a.m.)...Right forearm INT intact/patent...1000 (10:00 a.m.)...skin condition warm, dry, intact...1700 (5:00 p.m.)...NS infusing to RFA (right forearm)...no s/s infiltration noted...2100 (9:00 p.m.)... IV has infiltrated...2215 (10:15 p.m.)...attempted x 2 to obtain IV access. Unable to obtain..." Review of the Skin/Wound Assessment Record form dated August 6, 13, 20 and 27, 2012, revealed "...no alteration in skin integrity...". Further review revealed no documentation on the back of the form. Interview with Licensed Practical Nurse (LPN) # 3	F 282		

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F 282	Continued From page 20 on August 30, 2012, at 8:24 a.m., in the hall outside room 105, revealed the LPN was aware of the bruises and thought they were from multiple IV sticks but failed to document the bruising. Interview with the Assistant Director of Nursing (ADON) in the minimum data set office on August 30, 2012, at 8:41 a.m., confirmed the Certified Nurse Aide and bath aide were to report bruising. Further interview confirmed the nursing notes from August 24 to 30, 2012, lacked documentation regarding the bruising to the tops of both hands. Further interview confirmed the wound nurse was responsible to update the documentation on the back of weekly skin report if notified of skin issue. Further interview confirmed the computerized CNA and nursing documentation from August 24 to 30, 2012, revealed no documentation of skin issues. Interview with the wound care nurse on August 30, 2012, at 9:00 a.m., at nursing station 1, confirmed the wound care nurse had "..noted bruising yesterday when doing tube feeding site treatment..." Further interview confirmed the wound care nurse had not documented the bruising observed on August 29, 2012, during the tube feeding site treatment. Interview with Certified Nurse Aide #6 (bath aide) on August 30, 2012, at 9:40 a.m., outside the resident's room, revealed resident #119 last had a bath on Monday (August 27, 2012), the CNA had noticed bruising on both hands, and did tell a nurse though could not recall which nurse. Further interview with the CNA revealed the nurse had told the CNA the nurse was aware of the	F 282		

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F 282	Continued From page 21 bruises and they were due to multiple IV sticks. Interview with the Director of Nursing (DON) on August 30, 2012, at 12:15 p.m., in the social services office, confirmed no investigation of the cause of the bilateral hand bruises or documentation of bruising had been completed for resident #119.	F 282		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to implement new interventions after a fall for one resident (#81); failed to conduct an investigation to implement interventions related to a resident to resident altercation for one resident (#142); failed to ensure a safety device was activated for one resident (#148); and failed to accurately assessess a fall for one resident (#33) of six residents with accidents of forty residents reviewed. The findings included: Resident #81 was admitted to the facility on June 26, 2012, with diagnoses including Alzheimer's	F 323		

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F 323	Continued From page 22 Disease, Dementia, Psychosis, Hypertension, Chronic Kidney Disease, Parkinson Disease and Depression. Medical record review of the significant change Minimum Data Set (MDS) dated July 2, 2012, revealed the resident scored a four on the Brief Interview for Mental Status indicating the resident was severely cognitively impaired and required extensive assistance with activities of daily living. Medical record review of the Care Plan dated July 10, 2012, revealed the resident had "personal history of falls and at risk for injury...assist in transfers...non-skid shoes and socks...tab alarm while in bed and in chair...staff to make frequent checks on resident..." Medical record review of a nurses note dated July 29, 2012, at 5:05 a.m., revealed, "...entered room and found resident lying in the floor on the right side...denies any pain or discomfort...alarm in use..." Medical record review of the care plan after the fall dated July 30, 2012, revealed, "...pharmacy to review the meds (medications)..." Medical record review of the Pharmacy Consultation form dated July 31, 2012, revealed, "...Morphine, Ativan and Seroquel place the resident at risk for falls...please ensure that resident is on the lowest effective dose of these medications to decrease the risk of falls..." Medical record review of the Pharmacy Consultation sheet with the physician's comments dated August 12, 2012, revealed, "...will review	F 323	1. Care Plan for Resident #81 has been updated with physician's response to the Pharmacist's recommendations. 2. All residents with recommendations from Pharmacy have been checked to assure care plan is updated. 3. An inservice will be held with all nurses to assure care plans are updated as appropriate. Nurse requesting pharmacy recommendations will follow up to assure recommendation was done and proper follow up documented. 4. The Director of Nursing or her designee will monitor the compliance with follow up and report to the Quality Assurance Committee.	10/14/12

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F 323	Continued From page 23 meds periodically and lower doses as needed..." Observation on August 29, 2012, at 7:32 a.m., in the resident's room, revealed resident #81 lying on the bed, two full side rails in place and a bed alarm in use. Interview with the unit manager, Registered Nurse (RN) #1, on August 30, 2012, at 2:30 p.m., in the unit mangers office, confirmed the resident had a fall on July 29, 2012, the pharmacy consultation was done on July 31, 2012, and the facility failed to follow up or initiate new interventions until August 14, 2012, (14 days) after the fall. Resident #142 was admitted to the facility on June 13, 2012, with diagnoses including Schizophrenia, Bipolar Disease, Dementia, Atrial Fibrillation and Hypothyroidism. Medical record review of the 30 day MDS assessment dated July 11, 2012, revealed the resident had moderately impaired cognitive skills and required limited assistance with activities of daily living. Medical record review of a nurses note dated August 9, 2012, at 12:05 p.m., revealed, "...resident was struck by a confused resident...resident has a small abrasion on lower lip and chin...less than 1 centimeter...daughter here and aware of situation..." Medical record review of the Care Plan dated August 1, 2012, revealed, "...bed alarm, side rails to be down, non-skid socks..."	F 323	1. An investigation has been made into the altercation of Resident #142 and another resident. Appropriate revisions to the Care Plans of both residents have been made. 2. All residents have been reviewed for any incidents requiring investigation. 3. An inservice will be held with all nursing staff to assure proper documentation when there is any incident involving a resident. An incident report will be done, family and physician notified, orders properly followed and care plan revised. 4. A check sheet has been devised to monitor all incidents to assure proper care and documentation is done. The Incident/Falls Committee will review each incident and a member of the committee will follow up with the resident and medical record to assure proper care, documentation in the medical record and accurate revision to the care plan. The Committee will report results to the Quality Assurance committee.	10/14/12

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F 323	Continued From page 24 Observation on August 29, 2012, at 7:40 a.m., in the 500 Wing hallway, revealed the resident sitting in a wheel chair with a chair alarm in use. Interview with Licensed Practical Nurse (LPN) #4 on August 29, 2012, at 2:30 p.m., in the 500 Wing Nurses Station, revealed the resident had an altercation with another resident in the activities room but the altercation was de-escalated very quickly by separating the residents. Interview with the Director of Nursing (DON) on August 29, 2012, at 3:00 p.m., in the conference room, confirmed the DON was aware of the altercation and the facility failed to complete an investigation to implement interventions to prevent further altercations. Resident #148 was admitted to the facility on August 16, 2012, with diagnoses including Alzheimer's Disease with Behaviors, Delusions, Agitation, Hypertension, Diabetes Mellitus Type 2, and History of Falls. Review of the admission MDS dated August 24, 2012, revealed the resident scored a one on the Brief Interview for Mental Status indicating the resident was severely cognitively impaired and required extensive assistance with activities of daily living. Medical record review of the Falls Selection Form dated August 24, 2012, revealed the resident was "...high risk for falls...resident very unsteady with walk and transfers...behavior- tried to stand or walk alone unsafely..." Medical record review of the nurse's notes	F 323	1. Resident #148 has a functioning chair alarm presently in use. 2. All residents requiring a chair alarm have been checked to assure the alarm is in place and functioning properly. 3. An inservice will be held with all nursing staff to assure that the alarms are in place and functioning properly. 4. A check sheet will be used to identify all residents requiring chair alarms and to assure the nurses and assistants are checking the alarms for proper functioning and placement. Members of the Falls/Incidents Committee with make random checks to assure the above measures are followed and report to the Quality Assurance Committee.	10/14/12

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F 323	Continued From page 25 revealed the resident had fallen on August 17, 2012, at 2:45 a.m., while in the resident's room unattended, and suffered a laceration to the right side of the forehead and a skin tear to the right elbow. Medical record review of the nurse's notes dated August 24, 2012, at 4:10 a.m., revealed, "...found in the floor in the hallway outside the resident's room...multiple skin tears on right arm and hand, large hematoma to right side of forehead...right finger skin tear..." Medical record review of a nurses note revealed, "...fell on August 24, 2012, at 2:50 a.m., in the resident's room...elbow bleeding..." Medical record review of the Care Plan dated August 17, 2012, revealed, "...make frequent rounds on resident due to falls..." Continued review revealed an update on August 24, 2012, "...Falls Risk: tab alarm to alert staff of unsafe transfer...maintain safe environment..." Observation on August 27, 2012, at 11:20 a.m., in the activity room, revealed the resident lying on the floor with no staff in the activity area. Further observation revealed a geri-chair beside the resident, and the chair alarm was not sounding. Continued observation revealed at 11:22 a.m., LPN #4 and Certified Nurse Assistant (CNA) #1 came into the activity room, assisted the resident into the geri-chair and transported the resident to the resident's room. Interview with LPN #4 and CNA #1, on August 27, 2012, at 11:25 a.m., in the resident's room, revealed the resident was a "...frequent faller..."	F 323		

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F 323	Continued From page 26 and confirmed the chair alarm was not activated at the time of the fall. Resident #33 was admitted to the facility on November 14, 2006, with diagnoses including Diabetes Mellitus, Arthritis, Urinary Tract Infection, Decubitus Ulcer of Coccyx, Hypotension, Spasm of Muscle, history of Cerebral Vascular Accident, Alzheimer's Disease, Demetia, Osteoarthritis, Degenerative Joint Disease, Osteoporosis, Right Clavicle Fracture, Chronic Obstructive Pulmonary Disease, Debility, Congestive Heart Failure, Depression, Anxiety, Abnormality of Gait, Conductive Hearing Loss, Insomnia, Muscle Weakness, and Lack of Coordination. Medical record review of Minimum Data Set Annual Assessment dated July 5, 2012, revealed the resident was unable to ambulate and required extensive assistance to transfer. Medical record review of the nurses notes dated August 10, 2012, at 10:15 p.m., revealed the resident was heard screaming from another resident's room, and was found by Certified Nursing Assistant (CNA) #2 on the floor. Further medical record review revealed the resident was transferred to an acute care hospital the following day. Review of the Post Fall Investigation report dated August 13, 2012, revealed CNA #2 witnessed the fall when it occurred. Further review of the investigation revealed the resident was	F 323	1. The documentation on the Medical Record of Resident #33 has been amended by late entry to denote the resident was not ambulating in wheelchair at the time of incident. The CNA did not directly see the event but just heard it happen from the hallway. 2. All recent incidents have been reviewed to assure all facts are as stated or revised as appropriate. 3. An inservice will be held with all nursing staff to assure correct documentation is done on all incident. 4. A check sheet has been devised to monitor all incidents to assure proper documentation is done. The Incident/Falls Committee will review each incident and a member of the committee will follow up with the resident and medical record to assure accurate documentation in the medical record. The Committee will report results to the Quality Assurance committee.	10/14/12

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F 323	Continued From page 27 ambulating in the room unattended at the time of the fall. Interview with Registered Nurse (RN) #1 and LPN #5 on August 30, 2012, at 1:15 p.m., in the station one medication room, confirmed the resident was not ambulatory at the time of the fall and had not been for some time. Further interview with LPN #5 revealed CNA #2 was not in the room at the time of the accident, had only overheard the incident, and the facility had failed to accurately investigate the fall.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, nutritional assessment review, medical record review, laboratory data review, and interview, the facility failed to administer a physician ordered protein supplement, Prostat, for the month of August 2012 for one (#134) of ten residents reviewed for nutrition of thirty-two residents.	F 325		

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F 325	Continued From page 28 The findings included: Resident #134 was admitted to the facility on April 18, 2012, with diagnoses including Alzheimer's Disease, Alzheimer's Dementia with Behaviors, Chronic Obstructive Pulmonary Disease, Dysphagia, and Anxiety. Observation on August 29, 2012, beginning at 8:11 a.m., of the station two dining room revealed resident #134 was seated at the dining room table. Observation at 8:25 a.m., revealed the resident self feeding the morning meal consisting of scrambled eggs, pureed meat, biscuit with gravy, eight ounces each of milk, juice, and coffee. Observation at 8:35 a.m., revealed the resident had consumed one hundred percent of the main plate, zero percent of the milk, and twenty-five percent of the juice. Further observation at 8:38 a.m., revealed the resident was transported to the lounge area. Observation on August 29, 2012, beginning at 1:09 p.m., of the station two dining room revealed resident #134 self feeding at the dining room table and was later fed by the facility staff. Further observation revealed the resident meal consisted of mashed potatoes, pureed meat, squash casserole, soup, and eight ounces each of iced tea and milk. Further observation revealed the resident had consumed seventy-five percent of the milk and over fifty percent of the main plate items. Review of the Nutritional Assessment dated July 17, 2012, revealed the resident's "...protein needs at 41- 45.1 (grams);...low albumin...will add 1 oz (ounce) Prostat (protein supplement) BI (sic) for	F 325		

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F 325	Continued From page 29 added protein and calorie, each 1 oz provides 72 calories and 15 grams of protein..." Medical record review of the nutrition care plan dated May 7, 2012, with revisions dated July 17, 2012, revealed "...Albumin low...Goal: ...Albumin improve with consuming 1 oz Prostat BID (two times daily)...Approach:...Staff to assist patient with all meals..." Medical record review of the interim care plan dated July 3, 2012, revealed "...added 7/17/12 1 oz Prostat BID at med pass..." Medical record review of the nutrition care plan dated July 24, 2012, revealed Problem "...Low Albumin...Goal...consume prostat as ordered to see improvement in Albumin...Approach:...Nursing to give 1 oz. prostat BID to see improvement in Albumin..." Medical record review of the laboratory data dated April 19, 2012, revealed the albumin serum (protein) level was 3.0 and on July 8, 2012, the albumin serum level was 2.9. The normal range for albumin serum was 3.4 - 5.0 gm/dl (grams per deciliter) Medical record review of the physician orders revealed a phone order dated July 17, 2012, for "1 oz (ounce) Prostat (protein supplement) BID (twice daily) at med pass". Medical record review of the August 2012 Recapitulation Physician Order signed by the physician on August 1, 2012, revealed "...1 oz. Prostat BID at med pass...".	F 325	1. Resident #134 is receiving Prostat as ordered. 2. All residents with an order to receive Prostat have been reviewed to assure it is given as ordered. 3. An inservice will be held with all nursing staff to assure Prostat is given as ordered. Times of administration of Prostat have been changed to not be given at medication pass, therefore allowing the resident more time for consumption of nutritional supplement. 4. The Director of Nursing or her designee will audit all residents receiving Prostat to assure it is given as ordered and report to the Quality Assurance Committee.	10/14/12

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F 325	Continued From page 30 Medical record review of the August 2012 Medication Administration Record (MAR) revealed "...1 oz Prostat BID at med pass..." with the words written in "See med (medication) sheet." Further review of the medication sheets revealed no documentation of the Prostat. Interview with the direct care Licensed Practical Nurse (LPN) #1, on August 27, 2012, at 11:56 a.m., at nursing station 2; and on August 29, 2012, at 9:05 a.m., in the hallway outside room 710, confirmed the MAR dated August 2012 had "see med sheet" written in the area of the 1 oz Prostat BID at med pass. Further interview confirmed the documentation and administration of the Prostat should have been written on the MAR but it was not. Further interview confirmed there was no documentation the Prostat had been administered to the resident for the entire month of August 2012. Further interview confirmed the medication cart contained two open bottles of Prostat dated August 4, 2012, and August 21, 2012. Further interview confirmed the Prostat was available and the facility failed to administer the supplement per the physician order.	F 325		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses.	F 356		

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F 356	Continued From page 31 - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to accurately post the nurse staffing ratio. The findings included: Observation on August 27, 2012, at 10:20 a.m., in the front entrance area, revealed nurse staffing information was posted near the business office entrance, and the date on the report was for August 24, 2012. The staffing report indicated for day shift (7a.m. - 3 p.m.) one RN (Registered Nurse) and five LPNs (Licensed Practical Nurse) working with total hours for RN was eight and the total hours for LPN was eight.	F 356	1. The Daily Nurse Staffing Sheet is being posted daily and correctly includes the facility name, current date, the total number and actual hours worked by registered nurses, licensed practical nurses and certified nursing assistants per shift as well as the resident census. 2. The Daily Nurse Staffing Sheets for the past month have been corrected. 3. An inservice was held with the nurses responsible to completing the sheets to assure proper understanding of the procedure. The instructions for completing the sheet have been copied to the back of the Daily Nurse Staffing Sheet to assure any nurse completing the form has proper instructions. 4. The Director of Nursing or her designee will review the sheet daily to assure completeness and proper retention.	10/14/12

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F 356	Continued From page 32 Interview with the Director of Nursing on August 27, 2012, at 11:30 a.m., in the Director of Nursing office, confirmed the posted staffing was incorrect and was not current.	F 356		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431		

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F 431	Continued From page 33 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of facility's policy, and interview, the facility failed to ensure proper and safe storage of drugs and biologicals in three of the three medication rooms reviewed, and in two of four medication carts reviewed; and failed to date and time an intravenous medication bag on two days for one (#119) resident of thirty-seven residents reviewed. The findings included: Observation of station one medication room on August 28, 2012, at 2:25 p.m., with Licensed Practical Nurse (LPN) #3, revealed a box of oatmeal containing five individual servings which had expired in July, 2012, mixed with medications on shelf. Interview with LPN #3 on August 28, 2012 at 2:45 p.m., in the station one medication room, confirmed the oatmeal was outdated and mixed with medications. Observation of the station one medication room on August 28, 2012, at 2:30 p.m., revealed the following: four bottles of Normal Saline, opened, undated, and partially empty; one bottle of sterile water, opened and undated; thirty-one blue lab tubes for blood collection, expired July, 2012; thirteen 20g (guage) x 1 inch IV (Intravenous) needles expired in January, 2010; one 20g x 1	F 431	1. No food items are mixed with medications. 2. All medication rooms have been reviewed to assure no food items are mixed with medications. 3. An inservice will be held with all nursing staff to assure food items are not mixed with medications. A separate locked storage area has been made available for food items in each medication room. 4. A check sheet has been devised for weekly checks to assure food items are not mixed with medications. A member of the nursing or administrative staff will conduct the weekly checks A report of the checks will be made to the Quality Assurance Committee. 1. All opened, undated or expired saline, sterile water, blood collection tubes, needles, sterile q tips and glucose strips have been removed from the Station 1 Medication Room. 2. All areas have been checked for opened, undated or expired saline, sterile water, blood collection tubes, needles, sterile q tips and glucose strips and have been removed.	10/14/12

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F 431	Continued From page 34 inch IV needle expired in April, 2010; three sterile Q-tips expired in July, 2011; and one bottle containing seven glucose test strips opened and undated on the medication cart of the 400 wing. Review of facility policy entitled "Expired Medications" revealed all multiple dose vials of medication and all Insulin were to be dated upon opening. Review of facility policy entitled "Expired Supplies" revealed all supplies should be checked for manufacturer's expiration date, and were to be disposed of as needed. Interview with LPN #3 on August 28, 2012, at 2:45 p.m., in the station one medication room, confirmed the expired medications and supplies had not been disposed of and the facility had failed to ensure proper and safe storage of drugs and biologicals. Observation of the emergency drug kit (ER kit) in station one medication room on August 29, 2012, at 1:15 p.m., with LPN #8, revealed the ER kit had been opened at 5:00 a.m. to remove Augmentin for a patient. Further observation revealed the kit had been left open. Review of the facility policy entitled "Emergency Pharmacy Service and Emergency Kits" revealed the kits were to be resealed upon opening with a color coded lock to indicate need for a replacement kit. Interview with LPN #8 in the station one medication room on August 29, 2012, at 1:30 p.m., confirmed the ER kit had been opened and	F 431	3. An inservice will be held with all nursing staff stressing the importance of proper dating of opened items and disposing of outdated medications and supplies. 4. A check sheet has been devised for weekly checks to assure opened items are properly dated. A member of the nursing or administrative staff will conduct these checks. A report of the checks will be made to the Quality Assurance Committee. 1. The Emergency Drug Kit on Station 1 is properly secured. 2. The Emergency Drug Kit on Station 1 has been checked daily for past 2 weeks to assure it is secured properly. 3. An inservice will be held with the nursing staff to reinforce the importance of adhering to the "Emergency Pharmacy Service and Emergency Kits" policy. The "Daily Communication Sheet" will be revised to document the opening of the Emergency Kit. 4. The Director of Nursing or her designee will monitor the Emergency Kit daily to assure compliance. A report of compliance will be made to the Quality Assurance Committee.	10/14/12 10/14/12

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F 431	Continued From page 35 not resealed, thus failing to ensure proper and safe storage of medications. Observation of station two secure unit medication room on August 28, 2012, at 2:00 p.m., with LPN #2 revealed the following: a bottle containing fifteen opened and undated glucose test strips in the medication cart; a bottle of Lantus Insulin in the medication cart opened and undated; a jar of sauerkraut on the shelf of the medication room which had expired in June, 2012, sitting next to a Fleets enema; and a box of Swiss chocolate rolls which expired on August 17, 2012, on the shelf. Further observation revealed several xerofoam dressings in the treatment cart which had expired on November, 2009. Interview with LPN #2 on August 28, 2012, at 2:15 p.m., in the medication room of the secure unit, confirmed the facility had failed to ensure safe and proper storage of drugs and biologicals. Observation of the station two medication cart (nonsecure unit) on August 28, 2012, at 2:15 p.m., with LPN #1 present, revealed one bottle containing one glucose test strip, opened and undated. Observation of the station two (nonsecure unit) medication room on August 29, 2012, at 1:25 p.m., with LPN #1 present, revealed the ER kit had been opened on August 24, 2012, and was left unlocked and had not been reordered from the pharmacy. Further observation of the medication room revealed a bottle of thickener which had expired July, 2012, on the shelf. Interview with LPN #2 on August 28, 2012, at	F 431	1. All opened undated glucose strips and insulin, food items and expired dressing have been removed from the Station 2 Secured Unit medication room. 2. All areas have been checked for opened undated glucose strips, insulin, food items and expired dressings and have been removed. 3. An inservice will be held with all nursing staff stressing the importance of proper dating of opened items, disposing of outdated medications and supplies and not storing food items with medications. A locked area has been designed on Station 2 Secured Unit medication room for resident non medication items. 4. A check sheet has been devised for weekly checks to assure opened items are properly dated and food items are not stored with medications. A member of the nursing or administrative staff will conduct these checks. A report of the checks will be made to the Quality Assurance Committee.	10/14/12

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 36 2:30 p.m., in the secure unit medication room, confirmed the facility had failed to ensure safe and proper storage of the drugs and biologicals. Observation during medication pass on August 29, 2012, between 4:23 and 5:00 p.m., revealed Registered Nurse (RN) #2 administered medications to three different residents on two separate hallways. Observation revealed RN #2 obtained medications for resident #119, entered the resident's room at 4:32 p.m., without locking the medication cart, and administered medications to the resident. Continued observation revealed RN #2 exited resident #119's room at 4:38 p.m., and moved the medication cart to the end of the 200 hallway, and left the medication cart unattended and unlocked to throw trash in the biohazard room. Continued observation revealed RN #2 moved the medication cart to the 300 hallway, entered resident #72's room, with the medication cart unlocked, and asked the resident a question regarding medications. Continued observation revealed RN #2 exited the resident's room and locked the medication cart at 4:46 p.m., before walking to the station 1 nursing desk. Continued observation revealed RN #2 returned to the 200 hallway, obtained medications for resident #8 at 4:59 p.m., locked the medication cart, and entered the resident's room to administer medications. Continued observation revealed RN #2 exited the room, unlocked the medication cart to obtain supplies to check the resident's blood sugar, and returned to the resident's room, without locking the medication cart at 5:02 p.m.	F 431	1. The Emergency Drug Kit on Station 2 is properly secured. All opened undated glucose strips and expired thickeners have been removed from the Station 2 unsecured unit medication room. 2. The Emergency Drug Kit on Station 2 has been checked daily for past 2 weeks to assure it is secured properly. All medication rooms have been checked for opened undated glucose strips and expired thickeners. 3. An inservice will be held with the nursing staff to reinforce the importance of adhering to the "Emergency Pharmacy Service and Emergency Kits" policy, proper dating of glucose strips when opened as well as the removal of expired thickeners. The "Daily Communication Sheet" will be revised to document the opening of the Emergency Kit. 4. The Director of Nursing or her designee will monitor the Emergency Kit each time it is noted to have been opened on the "Daily Communication Sheet" and randomly to assure compliance A report of compliance will be made to the Quality Assurance Committee.	10/14/12

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	445126	A. BUILDING _____ B. WING _____	08/30/2012

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F 431	Continued From page 37 Interview with RN #2 outside resident #8's room on August 29, 2012, at 5:06 p.m., confirmed the medication cart had not been locked every time it was left unattended and medications had not been secured. Resident #119 was admitted to the facility on June 22, 2012, with diagnoses including After Care for Healing Ankle Fracture, Hypertension, Atrial Fibrillation, Upper Respiratory Infection, and Urinary Tract Infection. Medical record review of the physician orders revealed a phone order dated August 24, 2012, for "...3) Clindamycin (Antibiotic) 600mg (milligrams) IVPB (Intravenous Piggyback) q (every) 8hr (hour)..." Review of the facility policy entitled Intravenous Medication Administration with the reviewed and revised date of August 2012 revealed "all IV medications will be labeled with...date, time..." Observation on August 27, 2012, at 11:28 a.m., of the intravenous (IV) therapy hung for resident #119, revealed a bag with the typed label of "Clindamycin 600mg in NS (normal saline) 100ml (milliliters) x (times) 10 days infuse 600mg (milligrams) IV over 30 min (minutes) every 8 hr (hours) 8/24/12." Interview on August 27, 2012, at 11:55 a.m., in the 100 hall medicine room with Registered Nurse (RN) #4 confirmed the 8:00 a.m. intravenous dose of Clindamycin was not labeled with the date and time the dose was given nor the	F 431	1. RN #2 is locking her cart when it is unattended. 2. All medication nurses have been observed in the past week to assure medication carts are locked while unattended. 3. An inservice will be held with all nursing staff stressing the importance of locking the medication cart when unattended. 4. The Director of Nursing or her designee will monitor medication nurses to assure the medication carts are locked when unattended. The results of these reviews will be reported to the Quality Assurance Committee.	10/14/12

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F 431	Continued From page 38 name of the person administering. Continued interview revealed "...we are supposed to label each bag with the date and time of the dose and our initials, I forgot to do that on the 8:00 a.m. dose I hung..." Observation on August 29, 2012, at 8:00 a.m.,in the resident's room, revealed Clindamycin hung with the time of 2400 but no date. Interview on August 29, 2012, at 8:10 a.m., in the resident's room, with Licensed Practical Nurse (LPN) #3 confirmed the Clindamycin was hung at 2400 and was not dated for date when hung.	F 431	1. All intravenous medications currently being given have proper documentation on the medication bag. 2. All intravenous medications have been checked for proper documentation. 3. An inservice will be held with all nursing staff stressing the importance of proper documentation of intravenous medications. 4. The Director of Nursing or her designee will monitor all medication nurses to assure the proper documentation on all intravenous medications given. The results of these reviews will be reported to the Quality Assurance Committee.	10/14/12
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		

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F 441	Continued From page 39 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure infection control practices were followed for a wound dressing change for one (#8) of seven residents with wounds; failed to ensure clean linen was protected from possible contamination for one of two nursing stations; failed to ensure the thermometer was sanitized during food temperature checks in the dietary department; and failed to ensure hand hygiene was followed during dining observations for one of four dining rooms. The findings included: Observation of a dressing change for resident #8 on August 30, 2012, between 7:30 a.m., and 8:00 a.m., in the resident's room, with Licensed Practical Nurse (LPN) #6, revealed the resident had a stage 4 pressure ulcer to the left hip which measured approximately 0.8 cm (centimeters) by	F 441		

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F 441	Continued From page 40 0.5 cm, with a depth of 0.2 cm, and the wound had no visible drainage or bleeding. Observation revealed LPN #6 cleaned the over bed table, applied a barrier to the over bed table and placed wound care supplies, including a 12 oz (ounce) spray bottle of wound cleanser, on the covered over bed table. Continued observation revealed, after removing the old dressing, LPN #6 removed soiled gloves, sanitized the hands, applied clean gloves, and held the spray bottle of wound cleanser close to (within one inch of) the resident's wound and sprayed cleanser on the wound for cleaning with gauze sponges. Continued observation revealed LPN #6 placed the wound cleanser bottle on the over bed table, removed the gloves, sanitized the hands, and proceeded with the wound dressing change. Continued observation revealed, after completing the dressing change, LPN #6 replaced the bottle of wound cleanser into the treatment cart outside the resident's room without disinfecting the bottle. Interviews with LPN #6 on August 30, 2012, at 8:00 a.m., outside resident #8's room, at 9:10 a.m., in the Social Service office, and at 9:18 a.m., in the treatment nurse office, confirmed the facility had seven residents receiving wound dressing changes requiring wound cleanser and LPN #6 had only three bottles of wound cleanser. Further interviews confirmed the wound cleanser bottle was not always disinfected between uses during dressing change on different residents. Observation of a Storage Room on Station 1 on August 30, 2012, at 7:55 a.m., revealed when a locked door to the storage room was opened there was a room with carts of uncovered clean linen to the right of the room and stored medical	F 441	1. The wound cleaner bottle is being disinfected after each use. 2. All wound cleaner bottles involved in dressing changes are being disinfected after each use. 3. An inservice will be held with all nursing staff to stress the importance of disinfecting the wound cleaner bottle after each use. 4. The Director of Nursing or her designee will monitor dressing changes to assure proper disinfection of wound cleaner bottles. A report will be submitted to the Quality Assurance Committee. 1. Storage Room on Station 1 has a barrier between the clean linen and the passage to the biohazard storage. 2. All areas containing clean linen have been checked to assure they are covered to prevent contamination. 3. An inservice will be held with all nursing staff to assure clean linen is covered at all times to prevent contamination.	10/14/12

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F 441	Continued From page 41 records to the left of the room. Further observation revealed towards the back of the room, behind the clean linen carts, was a closed door with a sign indicating Biohazard Waste. Observation of the biohazard waste room revealed boxes in the room for storage of red bagged biohazardous waste and signs indicating biohazardous waste was contained within the room. Interview with the Director of Nursing (DON) on August 30, 2012, at 4:43 p.m., in the DON's office, confirmed staff had to pass through a clean area to access the biohazard room, and the clean linen was to be covered to prevent contamination. Observation on August 27, 2012, at 12:12 p.m., of the resident mid-day meal tray line revealed the cook obtaining food temperatures. Further observation revealed the cook failed to sanitize the thermometer between each food item. Interview with the cook obtaining the tray line temperatures on August 27, 2012, at 12:24 p.m., confirmed the thermometer was not sanitized between each food item. Observation on August 27, 2012, at 1:30 p.m., in the 500 Wing dining room, revealed resident #97's legs were on the dining table. Continued observation revealed the resident took socks off, threw socks on the floor and put a dirty cover sheet onto the dining table. Continued observation of Certified Nurse Assistant (CNA) #4 revealed the CNA pulled the resident up in the	F 441	4. A check sheet has been devised to monitor that all clean linen is properly covered. A member of the nursing or administrative staff will conduct these checks. A report will be made to the Quality Assurance Committee. 1. The food thermometer is being sanitized between each food item. 2. All meals in the past two weeks have been monitored to assure the food thermometer was sanitized between each food item. 3. An inservice was held with all dietary personnel to assure proper procedure is followed when using food thermometer. 4. The Dietary Director or her designee will monitor the taking of food temperatures to assure proper procedure is followed.	10/14/12 10/14/12

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F 441	Continued From page 42 chair, put the socks back on the resident's feet and covered the resident up with the dirty cover sheet removed from the dining table. Further observation revealed the CNA retrieved the resident's food tray and set the tray up for the resident to eat without washing or sanitizing the hands after touching the dirty socks and dirty cover sheet. Continued observation revealed the CNA continued to assist two other residents with the food trays and failed to wash or sanitize the hands. Review of the facility policy, Hand Washing, with a revision date of February, 2010, revealed "...hands are to be washed before and after all personal patient care..." Interview with CNA #4 on August 27, 2012, at 3:15 p.m., in the 500 Wing Hallway, confirmed the CNA failed to wash or sanitize the hands after touching the dirty socks and dirty cover sheet. Interview with the Director of Nursing (DON) on August 27, 2012, at 4:15 p.m., in the conference room, confirmed the CNA failed to follow facility policy.	F 441	1. CNA #4 is washing or sanitizing hands before and after patient care. 2. Nursing staff has monitored all CNAs at meal times to assure proper hand sanitation is being done. 3. An inservice will be held with all nursing staff to emphasize the proper procedure is followed with the infection control policy regarding hand washing or sanitation. 4. The Director of Nursing or her designee will monitor the compliance with the hand sanitation policy and report to the Quality Assurance Committee.	10/14/12
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain laboratory work for two	F 502		

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F 502	Continued From page 43 residents (#91 and #114) of thirty-seven residents reviewed. The findings included: Resident #91 was admitted to the facility on May 30, 2012, with diagnoses including Heart Failure, Hypertension, Alzheimer's Disease, Cerebral Vascular Accident and Non-Alzheimer's Dementia. Medical record review of a physicians order dated August 1, 2012, revealed an order for a BMP (Basic Metabolic Panel), CBC (Complete Blood Count), TSH (Thyroid Stimulating Hormone) and T4 (Thyroid Hormone). Medical record review of the resident's laboratory values revealed the labs were not on the resident's chart on August 29, 2012. Interview with the Director of Nursing (DON), on August 30, 2012, at 10:30 a.m., in the conference room, confirmed the facility failed to obtain the BMP, CBC, TSH and T4 level as ordered for resident #91. Resident #114 was admitted to the facility on February 10, 2011, with diagnoses including Dementia, Hallucinations, Altered Mental Status, Encephalopathy, Hypothyroidism, Insomnia, Behavior Disorder, Alzheimer's Disease, Depression, Anxiety, Psychosis, and Delusions. Medical record review of a Psychotropic Med Mgt (Medication Management) Progress Note dated	F 502	1. Ordered laboratory tests (BMP, CBC, THS and T4) for Resident # 91 have been completed and are on the medical record. Ordered laboratory test (Lipid profile, HgA1c) for Resident #114 have been completed and are on the medical record. 2. All orders for laboratory reports have been reviewed and results obtained. 3. An inservice will be held with all nursing staff stressing the importance of following the proper procedure for obtaining specimens and results from the laboratory. Review of the current monitoring for receiving laboratory results will be done and changes made to more closely monitor that the specimens were drawn and the results received. Review of the current monitoring of recommendations from Paradigm's nurse practitioner (Psychotropic medication management) will be done and changes made to more closely monitor that recommendations are communicated to the physician and followed as ordered. 4. The Director of Nursing or her designee will monitor that specimens are obtained and results are received and results submitted to the Quality Assurance Committee.	10/14/12

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F 502	Continued From page 44 May 25, 2012, revealed the resident was receiving the following psychotropic medications: Remeron, Ativan, Lamictal, Exelon, Abilify, and Geodon. Further review of the progress note revealed, "...Lab/Technical Service Recommendation(s) for this Session: Lipid Profile, HgA1c (hemoglobin A1c for blood glucose control). Reason for Lab Recommendation(s): To monitor for metabolic effects of antipsychotic medication..." Medical record review of a Summary of Lab Recommendation(s) dated May 25, 2012, revealed, "...Pertinent Labs/Technical Services Recommendation(s): Lipid Profile, HgA1c. Reason for Lab Recommendation To monitor for metabolic effects of antipsychotic medication..." Review of the lab recommendation form revealed it was signed by the Nurse Practitioner on May 25, 2012, and the physician signed the form "Agree" on June 3, 2012. Medical record review revealed no documentation the labs had been obtained. Interview with the Director of Nursing (DON) on August 30, 2012, at 4:42 p.m., in the Social Service office, confirmed the lab was not obtained as ordered.	F 502		

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